

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31502

State File No. \_\_\_\_\_

Registrar's No. 26

Registration District No. 14

Primary Registration District No. 5482

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Sullivan Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 years. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Calumet Olive Tutterrow

8. (b) If veteran, name war No 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Perry Tutterrow 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July 28 1888  
(Month) (Day) (Year)

8. AGE: Years 55 Months 1 Days 12 If less than one day hr. min.

9. Birthplace Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name William E. Woodward  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ann Brink  
(City, town, or county) (State or foreign country)

15. Birthplace New Jersey  
(City, town, or county) (State or foreign country)

16. (a) Informant Grace Bodin  
(b) Address Maryland Heights, Missouri.

17. (a) Burial (b) Date thereof Sep. 12, 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cave Springs Cemetery

18. (a) Signature of funeral director Phyllis P. Shaffer

(b) Address Sullivan, Missouri.

19. (a) 9/11/43 (b) Gilbert Williams  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 036  
(c) City or town Sullivan, (Rural) 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10  
year 1943 hour 8 minute 40 PM.

21. I hereby certify that I attended the deceased from Sept 10 to Sept 10, 1943  
that I last saw him alive on Sept 7, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Chorion carcinoma  
Cause

Due to 200

Other conditions Amnionitis  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature Dr. Crato (M. D. or other) 0  
Address Sullivan Mo Date signed 9/11/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Edgar W. Lofgren*

Licensed Embalmer No.....

*3894*

P. O. Address.....

*Sullivan MO*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**